NACBHDD National Association of County Behavioral Health & Developmental Disability Directors
The voice of local authorities in the nation's capital

National Association of County Behavioral Health and Developmental Disability Directors

The voice of local authorities in the Nation's capital

NEWSLETTER

NOVEMBER 2015: POST-THANKSGIVING EDITION

ACA OPEN ENROLLMENT IS ON!

ACA open enrollment is November *1, 2015, to January 31, 2016.* In just the first 2 open-enrollment weeks, over 1 million people applied for coverage. Around 1/3 of the sign-ups were new customers, though not all are expected finish up by paying their premiums. And these figures don't take into account any applications taking place in states with their own marketplaces! That's good news. And, remember, people can enrollment in Medicaid or CHIP at any time. *Let's get everyone signed up for the health care coverage they need.*

LA COUNTY BEHAVIORAL HEALTH LEADER MOVES ON

Long-time Los Angeles County mental health director Marvin J. Southard, DSW, said goodbye to a job he had held since 1998 at a recent retirement party that included US Representative Grace Napolitano, co-chair of the Congressional Mental Health Caucus, who presented him with a Congressional award.

Over his 17 years at the helm of the—the largest public mental health system in the nation—Marv oversaw an enterprise that serves no fewer than 250,000 individuals annually, the diversity of which has continued to shift to become one of the most ethnically diverse counties in the country. Under his leadership, the agility of the Department has grown to meet the demand, as has its budget, which grew from just over $495 million in 1998 to almost $2 billion in 2015.

A licensed clinical social worker, Marv has served as president of the County Behavioral Health Directors Association of California and is a past president of the board of the California Social Work Education Center. He has been a board member of the California Institute for Behavioral Health Solutions, the PLAN of California, the National Network for Social Work Managers and the American College of Mental Health Administrators.

His dedication and leadership have been recognized with a number of awards, among them, from the National Network for Social Work Managers; the National Association of Social Workers' California Chapter; and the National Alliance on Mental Illness (NAMI).

He also has worked to educate the next generations of practitioners, holding academic appointments in the UCLA School of Medicine's Department of Psychiatry, the UCLA School of Public Policy and Social Research, and the University of Southern California Keck School of Medicine.

While leaving the county behavioral health scene, Marv isn't resting on his laurels. He's returning to academia—to the University of Southern California—where he'll be on the faculty of the School of Social Work. We look forward to seeing just where this new direction takes him and his longstanding commitment to improve the lives of people with behavioral disorders in Los Angeles, California, and the nation.

ALSO IN THIS ISSUE

Teddi Fine, MA, Editor

WHERE IT STANDS: IS THE MURPHY MEASURE AMENDED OR NOT; MOVING OR NOT? DEAD OR ALIVE?

The controversial Helping Families in Mental Health Crisis Act" (H.R 2646), Representative Tim Murphy's (R-PA) mental health reform bill that GOP leaders have hailed as a response to mass shootings, took another step toward adoption earlier this month. Earlier this month, the bill was the subject of a "mark-up" session by the House Energy and Commerce Health Subcommittee, chaired by Representative Joe Pitts (R-PA). That's when a bill is discussed, amended and either voted down or sent on for full committee consideration. The Murphy bill was approved by the Subcommittee along a party-line vote of 18-12, but not without considerable advance bloodshed.

Further, despite over 160 bipartisan cosponsors, the measure—introduced for the first time in the 114th Congress shortly after the Newtown shootings and again in this 115th Congress—is far from a done deal. And, as far as NACBHDD is concerned, that's not necessarily a bad thing.

WHAT ACTUALLY HAPPENED AT THE MARK UP SESSION? For a variety of reasons, the contentious mark-up session lasted far longer than anticipated. To begin, Murphy proposed a new version of his bill, shared just before the mark-up session began. Designed to push back against a Democrat-sponsored alternative measure, the revised Murphy bill added some new language and deleted some "high-price" provisions that had pushed CBO 10-year cost estimates as high as $46-$66 billion.

Nearly all of the full Committee's Democrats had come out against the measures provisions related to patient privacy laws, involuntary commitment (AOT) programs and dismantling SAMHSA, sharing their concerns in a letter to full Committee Chairman Fred Upton (R-MI) and ranking member Frank Pallone (D-NJ). Thus, when a substitute measure proposed by Subcommittee Democrats failed on a party-line vote early in the session, the battle was joined.

During what became a marathon meeting lasting all day Wednesday and into the night, Democrats offered 37 separate amendments that each were subject to debate and a vote. Serially, nearly all the Democratic amendments failed on party-line votes. It appeared to some in attendance that the GOP Subcommittee leaders made no effort to identify and adopt compromise language. And, ultimately, the "revised" Murphy bill was moved on to the full Energy and Commerce Committee for attention and action.

SO WHAT IS IN? WHAT IS OUT? The adopted, revised Murphy measure preserved many of the original problems and added further difficulties.

- It retains changes to HIPAA that allow health providers to give to caregivers and family members more information about a mentally ill person's care. However, Murphy did add language from Rep. Doris Matsui (D-CA) to provide training for doctors and patients about what the privacy law allows. *[NACBHDD wonders whether this provision might well cause consumers to opt out of treatment.]*
- It retains provisions to repeal SAMHSA and transfer some (but not all) of its programs and extensive oversight to an HHS Assistant Secretary for Mental Health and Substance Use Disorders.
- It maintains a provision that incentivizes states to adopt Assisted Outpatient Treatment (AOT), where judges can mandate treatment for patients with serious mental illness. The new language clarifies that while states adopting AOT would receive a 2% increase in funding, states not adopting AOT would not have their block grant funds rescinded. *NACBHDD wonders about the funding source for this 2% incentive funding.]*

Changes to the original bill, many of which were made to cut costs far below CBO estimates, compromise the measure still further. Provisions that would have eliminated Medicare's 180-day lifetime limit on psychiatric hospital care have been removed. Expansion of the "Excellence in Mental Health Act" set to pilot certified community behavioral health clinics (CCBHCs) also has been removed, as has support for behavioral health providers in federal health IT incentive funding programs.

The amended legislation also would allow states to shift funds between the Substance Abuse Prevention and Treatment Block Grant and the Mental Health Block Grant.

WHAT NEXT? The Murphy bill received a short-lived boost from newly elected Speaker Paul Ryan. In an interview with 60 Minutes, Ryan personally advocated for Murphy's bill, which he said could be a response to the nation's growing gun violence problem. But after the contentious mark-up session that never sought to reach consensus on divisive bill provisions, full committee markup could be put off until early next year, if then.

Without greater efforts to reach accord, the bill could become mired in controversy. Republican concerns continue to center on cost, particularly given earlier CBO 10-year projections. While some of the expenses were scaled back in the Subcommittee-approved measure—such as greater Medicaid coverage for mental health facility services—cost-cutting efforts continue. Moreover, the battles over AOT, privacy matters, the future of SAMHSA, and peer involvement continue as well. Stay tuned, stay alert, and keep advocating

BITS FROM DC

Dear Colleagues:

I would like to take this opportunity to recognize the outstanding accomplishments of our colleague, Dr. Marvin Southard, on the occasion of his retirement.

Marv has served as the Director of the Los Angeles County Department of Mental Health for more than 17 years. LA County is the largest mental health system in the United States, with more than 250,000 clients and a budget of more than $2 billion annually.

Throughout his career, Marv has made many, many contributions at the national, state, and county levels. Just at NACBHDD alone, he has helped us begin implementation of the Affordable Care Act, and he has helped us begin implementation of integrated care. He helped both by outstanding leadership for others and exemplary performance in LA County.

We will miss Marv; to keep him connected, we have elected him as an Emeritus Member of our Board.

Marv, hearty congratulations and very best wishes to you! We all know that you will continue to do important things for our field in the future.

To Marv and to all of you, I also want to wish a very warm and memorable Thanksgiving with family and friends. Thanksgiving is really about thanking others and being grateful for all that they do for us.

Ron Manderscheid, PhD
Executive Director

NEWS AND NOTES; COMINGS AND GOINGS

- **PARTNERSHIPS PROMOTING WIDER NALOXONE AVAILABILITY.** The National Association of Counties (NACo), the National League of Cities, and the US Conference of Mayors, working with the US Communities Purchasing Alliance and Premier, Inc., have secured industry-leading discounts for naloxone and medications containing buprenorphine. The cooperative purchasing agreement will improve public agency access to these potentially life-saving medications associated with reversing overdoses resulting from the use of heroin, prescription pain medications and other opioid drugs.
- **CHANGE AFOOT AT SAMHSA.** SAMHSA has been undergoing major changes of late, and not just its return to its earlier home at the HHS Parklawn Building in Rockville, MD. SAMHSA's had a number of staff changes and additions have been made. *Amy Haseltine* has moved to SAMHSA from the HHS Office of Grants and Acquisition Policy and Accountability to serve Acting Principal Deputy Administrator. Long-time consumer, recovery expert and advocate, *Tom Hill* has joined as Senior Advisor for Addiction and Recovery and will serve as Acting CSAT Director until a permanent hire is named. Rear Admiral *Pete Delany*, of the Center for Behavioral Health Statistics and Quality, has moved to ONDCP to assist with the President's opioid initiative. *Daryl Kade* will serve as Acting Director of CBHSQ. *Peggie Rice* joins as SAMHSA's Legislative Director. Finally, after too long without a senior physician onboard, SAMHSA just posted an announcement for a new chief medical officer.
- We sadly report the passing of one of the preeminent leaders in our field—*Dr. Beny Primm*. While his leadership in treating HIV infection and hepatitis C has long been established, he also leaves an indelible mark in substance abuse treatment. He was the founder and long-time executive director of the Addiction Treatment and Research Corporation, a large system of outpatient treatment programs in New York City's boroughs of Manhattan and Brooklyn. Dr. Primm also served as the Director of the Center for Substance Abuse Treatment, appointed by then-Secretary of HHS, Lewis Sullivan. In 1993, during his tenure at CSAT, the Center published its first Treatment Improvement Protocol, *State Methadone Treatment Guidelines*.

SNAPSHOT OF WHO'S INSURED AND WHERE

Enroll America has created new tools to help ascertain how the ACA has affected the uninsurance rate in states and counties across the nation. A regularly updated interactive map shows county-level changes from 2013 to 2015 [Go to: county insurance rate changes]. And detailed state-level information shows changes in uninsured rates by race/ethnicity, age, gender and county. [Go to: state profiles- uninsurance rates .]

HILL HAPPENINGS: THE GOOD, THE BAD AND THE UGLY

- **CHCHCHCHANGES**. With 236 of 435 votes, Rep Paul Ryan (R-WI) became the 54th Speaker of the House. Ryan's election gives House Republicans a chance to hit the reset button. We'll see if it actually happens! He'll have to deliver on some of the concessions he made to the far right of his party. With Ryan's ascent, his job as head of the Ways and Means Committee—responsible for some of CMS's portfolio—needed a new Chairman. That role will be filled by Rep. Kevin Brady (R-Texas). Replacing Brady as chair of the health subcommittee will be Rep. Pat Tiberi (R-OH). And, in a related move, Rep. Tom Rice (R-S.C.) fills the Committee vacancy resulting from Ryan's departure.

- **BUDGET BILL APPROVED**. In a 3 am, 64-35 vote, the Senate approved a 2-year budget deal that raised the debt ceiling through March 16, 2017, and raised spending levels through September 2017 by $80 billion above the sequestration levels. The increase is to be split evenly between defense and domestic programs. The House had previously approved the same measure by a vote of 266-167 (which includes 79 Republicans despite increased spending levels). Additionally, the measure averted the potential 52% premium hikes for certain groups of Medicare beneficiaries, including dual-eligibles, and it gave the SSDI fund a cash infusion, too. The bill already has been signed into law by the President.
- **TICK…TICK…TICK.** Despite passage of a 2-year budget bill, December 11 remains the day by which Congress must extend appropriations for FY 2016 or face a government shut-down. The biggest hurdle relates to funding for the National Institutes of Health (NIH). Both sides want to up the NIH budget, but the question of where the funds come from remains. Republicans want to shift funds to NIH from the programs of the Centers for Medicare and Medicaid Services and the Corporation for National and Community Service (Peace Corps/Vista), which already face funding cuts of 20% or more. Democrats argue the funds should come from the dollars newly available from the agreed-to hike in the budget cap above sequestration levels. And with the terror attack on Paris, security and refugee funding will likely also be part of the equation. It may be a bumpy flight.
- **GAMING THE SYSTEM**. Stay buckled in! The House of Representatives is using a special legislative rule—known as budget reconciliation—to tackle ACA repeal and Planned Parenthood defunding. Using the mechanism, the House approved the Restoring American's Healthcare Freedom Reconciliation Act in a party-line 240-189 vote. The measure would repeal key elements of the ACA, including both the individual and employer insurance mandates, the Prevention and Public Health Fund, and the requirement that large employers automatically enroll new full-time employees in a health care plan, among others. The measure also defunds Planned Parenthood for a year, transferring the projected savings to community health centers. The measure is now in the Senate, where budget reconciliation measures require only a 51 vote majority, since filibusters are not permitted. While it sounds as if it should be a Republican slam-dunk, the outcome is uncertain. While Senate GOP leaders had hoped to move the package before Thanksgiving, that plan was shelved. Not only do Senate Democrats oppose the measure, but right-wing Senators already have said they can support the measure only if it repeals the ACA altogether. And, don't forget, the White House has promised a veto.
- **MENTAL HEALTH MEASURES IN SENATE ALSO MOVING OR NOT**. As with the House, the prospects of a mental health reform measure being adopted are similarly mired down in the Senate, though more by the dreaded words "gun control" rather than by budget concerns. Sen. John Cornyn has been working to build support for his own mental health bill, which includes NRA endorsed language that could derail bipartisan efforts. Yes, it is déjà vu! That's precisely what stalled mental health legislation in the aftermath of the 2012 Sandy Hook school shooting.
- **CALL FOR PARITY FULL IMPLEMENTATION**. A bipartisan group of 22 Senators has written to both HHS and the Department of Labor calling for immediate action to implement the *Mental Health Parity and Addiction Equity Act* (MHPAEA) in full. They urged the Departments to conduct thorough audits and issue additional parity guidance so individuals seeking recovery and treatment for mental health disorders and substance abuse can access the benefits promised under the MHPAEA.
- **ACA'S IMD EXCLUSION DEMO EXTENDED**. In separate voice votes, the House and Senate approved an amended version of the Improving Access to Emergency Psychiatric Care Act (S. 599), originally introduced by Senators Ben Cardin (D-MD), Patrick Toomey (R-PA), and Susan Collins (R-ME). The measure was designed to extend the ACA's Medicaid Emergency Psychiatric Demonstration, slated to expire this year without Congressional action. The demonstration was created to determine if Medicaid reimbursement to treat psychiatric emergencies in patients ages 21 to 64 in private psychiatric facilities would increase the quality of care while reducing costs. The just-approved

legislation permits the 11 states and the District of Columbia now in the demonstration to continue through September 30, 2016, and, if the CMS chief actuary certifies the extension won't increase net Medicaid spending, through December 2019. The measure would allow HHS to add more states to the demonstration program under the same cost certification requirement. Congressional action would be required to permit demonstrations to continue after 2019. Further, HHS would be required to justify to Congress whether the program should be made permanent after 2019 and whether the program should be expanded to other states or nationwide.

- **STEPS CLOSER TO NEW FDA COMMISSIONER AND CMS ADMINISTRATOR—OR NOT.** The Senate Health, Education, Labor and Pensions Committee has confirmed the appointment of both Andy Slavitt to be CMS Administrator and Robert Califf to be the next FDA Commissioner. Slavitt's nomination has been pending a Senate vote since February when he was named by President Obama. Dr. Califf, a cardiologist, was nominated in September, following the departure of former Commissioner Peggy Hamburg. The hope was to approve their nominations rapidly. Unfortunately, Senator Ben Sasse (R-NE) has been holding up the nominations until he receives the answers he wants about the "failure" of 9 of the 23 ACA Co-op start-up insurer programs. Stay tuned.
- **ACA CO-OPS AT RISK**. Under the ACA, 23 states established health insurance co-ops as an alternative to traditional insurance coverage as part of their marketplaces. To date, despite having received some $2.4 billion in funding, nearly half of the 23 health insurance start-ups have shuttered. About half of the closures were announced just ahead of the open enrollment season that began November 1. While co-op enrollment had been low nationwide, the closures affect several hundred thousand people, all of whom have received information about how to remain enrolled. Budget conscious Republicans are concerned the money will not be recouped and have quickly held hearings by both the House Ways and Means and the Energy and Commerce Committees. The former focused generally on recent co-op failures; the latter focused its hearing on CMS failures and a recent HHS Inspector General audit report on the ailing finances of 21 of the 23 co-ops.
- **REDUCING VETS SUICIDE RISK.** A provision of the FY 2016 Military Construction and Veterans Affairs and Related Agencies Appropriations Act, now signed into law, requires an independent research program on the effects of combat service on suicide rates and other mental health issues among troops and veterans. The aim is not only to identify if combat exposure elevates suicide risk, but also to identify and eliminate the gaps and improve coordination of services between the Department of Veterans Affairs and the Department of Defense.

OVER THE FENCE:
NARMH PRESIDENT PRESENTS AT 2015 ROSALYNN CARTER MENTAL HEALTH SYMPOSIUM

NARMH President, Dr. Paul Mackie, presented research and recommendation at the 31st Annual Rosalynn Carter Mental Health Symposium November 12th, 2015. The presentation focused on issues associated with current challenges in hiring and retaining rural behavioral health providers. Dr. Mackie identified a variety of problems currently faced by rural communities, including:

- As much as 60% of rural America is underserved for behavioral health needs.
- Rural areas represent at least 85% of US behavioral health shortage areas, with 90% of psychologists/ psychiatrists and 80% of MSW social workers located in urban areas.
- Access to general or specialized behavioral health services in rural areas too often is limited or non-existent. When access to rural behavioral health services *is* available, the quality of care frequently is less than is available in urban areas.
- Over 2/3 of rural Americans get behavioral health care from primary care providers.
- Stigma associated with accessing services continues to be a serious and pervasive challenge, which creates additional challenges for providers.
- Hiring and retaining rural behavioral health practitioners continue to be an ongoing problem identified by rural-based supervisors and hiring officials.
- The use of teletechnology to "bridge the divide" (increase access) to behavioral health care continues to present challenges.

Mackie identified a number of reasons for the persistence of these challenges, among them the fact that: (a) rural America accounts for only 15-20% of the population; (2) lower levels of higher education in rural areas (18.5% with bachelor's degrees compared with 32% in urban areas) result in a reduced pool of potential indigenous providers; (3) rural areas seen as less "viable" or "desired" places to practice due to limited access to resources, supervision, social and professional opportunities, dual relationships, general challenges associated with geographic isolation; (4) perceived higher

levels of burnout in rural areas among potential practitioners; and (5) existing state & federal programs to promote rural practice, while responsive in the short term, lack long-term sustainability.

One specific point made clear is that research suggests that the overall difficulty in hiring rural social service providers is measureable and is defined by a three percent increase in difficulty in hiring for every ten miles one moves away from an urban center. These findings, coupled with other information known, strongly suggest that to successfully hire and retain rural practitioners, it may be best to focus recruitment efforts among rural residents, who we now know are more likely to return to practice in rural areas. Mackie put forward the overall recommendation of *Growing our Own Rural Practitioners* to best address the challenges at hand:

- Focus recruitment in rural areas toward youth and target populations more likely to become rural behavioral health providers.
- Create viable introductory pathways beginning with entry-level positions that can lead to higher practitioner levels.
- Develop advanced educational pathways through collaborations with higher education institutions, including online & extended education, focused rural internships, and infusion of rural-focused knowledge, skills, and curriculum development.
- Develop mentorship programs to support rural practitioners.
- Create funding opportunities to support pathways concept.
- Grants, scholarships, support for internships, educational advocacy, outreach.

The presentation's conclusion focused on the need to recognize that while many communities continue to struggle to properly staff behavioral health professionals, rural areas are especially difficult places to hire and retain these professionals. Further, Dr. Mackie claimed that rural areas are unique in culture, heritage, lifeways, and socio-economics compared to more populated areas and, as such, cannot readily adopt urban strategies to address rural needs.

The information shared in the presentation paralleled much of the information offered by many others throughout the 2-day symposium, as the event focused on behavioral health workforce challenges. The most notable difference was that this presentation focused uniquely on concerns more commonly identified in rural and small communities. We at NARMH want to sincerely thank Mrs. Carter and her outstanding staff for their commitment to keeping rural issues in sharp focus and working to strengthen rural America.

Note: References for statistics cited in this story are available on request from Dr. Mackie.

AROUND THE DEPARTMENTS AND AGENCIES

BILLIONS IN ACA PREMIUM REBATES TO CONSUMERS SINCE 2011. According to a new CMS report, the ACA requirement that insurers spend at least 80% of premium charges on health care (the 80/20 rule, or Medical Loss Ratio) has resulted in significant premium rebates. In 2014 alone, over 5.5 million consumers received nearly $470 million in rebates, for an average of $129 per family. The findings show that an increasing number of consumers are in plans where they are receiving more value for their premium dollars up front because their premium rates were set to reasonably reflect insurers' spending on medical care and quality improvement activities. The report covers rebates paid for the 2014 plan year, during which time insurers saw a substantial influx of previously uninsured consumers into health insurance markets as insurance reforms, financial assistance and premium stabilization programs took effect. Consumers who are owed a rebate for 2014 should have received a notice from their issuer by October 30, 2015. Read the report at: 2014 Medical Loss Ratio Report

- **NEW RESOURCE ON OPIOID ABUSE AND A LINK TO SAFE DRUG DISPOSAL.** HHS.gov/Opioids is a one-stop federal resource with tools and information for stakeholders including patients and providers, families and law enforcement, about prescription drug abuse; heroin use prevention, treatment & recovery; and overdose response. The HHS site links to a guide by the Partnership for Drug-Free Kids developed for communities seeking solutions for safe drug disposal. The guide identifies key issues for program developers to consider and provides resources to help them create safe drug-disposal programs in their communities. Check out the guide at: safe drug disposal
- **PARTNERING TO SERVE VETERANS.** The SAMHSA-HRSA Center for Integrated Health Solutions has developed *Serving Veterans: A Resource Guide* for primary and behavioral healthcare professionals serving veterans and their families. This online document provides important links to resources to give health professionals further tools and information to better

work with veterans and their families. Download the document at: http://www.integration.samhsa.gov.

- **IMPROVING DISCHARGE PLANNING IN MEDICARE/MEDICAID**. New CMS draft regulations would modernize discharge planning requirements that hospitals, long-term care and inpatient rehabilitation facilities, critical access hospitals, and home health agencies must meet to participate in Medicare and Medicaid. The changes would bring discharge requirements into closer alignment with current practice; help improve patient quality of care and outcomes; and reduce avoidable complications, adverse events and readmissions. The proposed rule would implement discharge planning requirements of the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act). Under the proposed rule, a mandatory discharge plan would be based on the goals, preferences and needs of each patient, helping people take charge of their own health care and future. Hospitals and critical access hospitals would be required to consider specific factors when evaluating a patient's discharge needs, including but not limited to the availability of non-health care services and community-based providers for patients post-discharge. Review and comment at: http://federalregister.gov/a/2015-27840. The 60 day comment period extends to January 3, 2016.
- **EVIDENCE BASED PRACTICE REGISTRY SUBMISSIONS SOLICITED.** SAMHSA is seeking candidates for its National Registry of Evidence-based Programs and Practices (NREPP), an online database of over 350 mental health and substance use interventions. *Submissions will be accepted from November 23, 2015–January 26, 2016.* To be considered, proposed interventions must meet 3 minimum requirements: (1) The research/evaluation of the intervention has assessed mental health/substance use outcomes among individuals, communities or populations; (2) Evidence of these outcomes has been demonstrated in at least one study using an experimental or quasi-experimental design; and (3) Study results have been published in a peer-reviewed journal or other professional publication, or documented in an evaluation report. For more information, go to: http://nrepp.samhsa.gov/04breviewsopen.aspx
- **VA-DOD INTEROPERABILITY MAY HAVE ARRIVED.** In a letter to the House Appropriations Committee, DoD Undersecretary Frank Kendall certified its interoperability with the VA under the terms of the 2014 National Defense Authorization Act. The interconnected VA/DoD system, which will become fully operational by mid 2016, links some 300 data sources including hundreds of VA facilities and the software systems used in Pentagon hospitals, clinics and battlefield stations. The letter stands in contrast to Hill complaints and a GAO report that the ability to share medical records between DoD and the VA is many years away. Only time will tell.
- **RETHINKING MEDICAID FOR NATIVE AMERICANS.** As reported, earlier the Medicaid program is reconsidering whether to reimburse 100% of private practice-provided primary and specialty care services not regularly available at IHS or tribal healthcare facilities. Currently, CMS reimburses at the standard Medicaid match, averaging 57%, nationwide. The agency is looking at a 100% federal match rate for these services, including hospital and outpatient care, as well as physician, laboratory, dental, radiology, pharmacy and transportation services. The issue that came to light during discussions about Alaska's Medicaid expansion plans also affects many states with significant tribal populations. With significant he financial implications, the decision will also be significant. Stay tuned.
- **2017-18 BASIC HEALTH PROGRAM FUNDING NOTICE**. A proposed CMS notice establishing the methodology for determining federal funding for the Basic Health Program (BHP) in program years 2017 and 2018 has been released. The BHP gives states the option to establish a health benefits coverage program for low-income individuals as an alternative to marketplace coverage under the ACA. This notice is mostly the same as the final FY 2016 notice. To view the proposed notice visit: http://www.medicaid.gov/basic-health-program/basic-health-program.html.

SOCIAL NETWORKING FOR BEHAVIORAL HEALTH

(PART 1 OF 2)

KIMBER WUKITSCH, MPH
Health Communication Consultant

Innovations in digital technology are slowly transforming the health care industry, from the growing practice of telehealth to the countless mobile apps that now measure biometrics, allowing individuals to track their own health data. The field of behavioral health care is not impervious to the benefits of such innovations, as experts seeking to improve patient outcomes and lower health care costs are researching and implementing the most effective uses of web-based and mobile health (mHealth) tools for individuals with mental illness and substance use disorders.

The widespread adoption of **social networking** — a broad term encompassing social media like Facebook and LinkedIn, along with many other online social

"networks" — represents one such technology that can be effectively leveraged within the practice of behavioral health care. According to Pew Internet's 2013 Health Online Survey, 72% of internet users reported searching online for health information within the past year, and 74% of those individuals also use social networking sites such as Facebook, Twitter and LinkedIn. [http://www.pewinternet.org/2013/01/15/health-online-2013]

Social networking provides an opportunity in health care for consumers to connect via virtual communities to receive moral support, set personal health goals, participate in research and much more. Behavioral health care is ripe for the connectivity inherent to online social networks, which can help individuals feel less alienated or stigmatized — and may even provide support for those who have limited or no access to mental health care. Many online behavioral health communities offer a safe, secure space for individuals to encourage each other in ways that promote health and well-being, such as maintaining medication regimens, scheduling (and keeping) provider appointments and making other personal decisions regarding their mental health.

Below is a partial list of such social networks that state and county behavioral health directors may use when providing resources to the communities they serve. These sites are a sampling of the social networks available to consumers with behavioral health conditions; others exist and should surely be explored.

Mental Earth Community. *Mental Earth Community (MEC)* is a free peer support website for adults with mental illness of any type and includes forums, blogs and live chat. Support forums pertain to various mood and personality disorders, chemical and behavioral addictions, abuse, stress and more. [http://www.mentaalearth.com]

Healthy Place. *Healthy Place*, self-described as "America's mental health channel," is a free social networking site focusing on mental health treatment and wellness. It features an online community of individuals diagnosed with a mental illness, their family members, loved ones and friends who seek information about mental health symptoms and treatments in a supportive community environment. [http://www.healthyplace.com]

WebTribes. *WebTribes* is an online space focused on bringing together communities of individuals suffering from various mental health illnesses, addictions and diseases, with the underlying belief that connecting with others in the community will have a positive effect on healing. "Tribes" are available for depression, anxiety, addiction and more. [http://www.webtribes.com/tribes.html]

Facebook Group: BDP, Depression, Mental Health Support Group. The *BPD, Depression, Mental Health* Facebook group has nearly 7,000 members and offers support for individuals suffering from Borderline Personality Disorder, Depression, or who are in need of general mental health support. Users must have a Facebook account. [https://www.facebook.com/groups/304799726382]

Patients Like Me. *Patients Like Me* is a free health data-sharing platform designed to "transform the way consumers manage their own conditions and improve patient care." While not specific to behavioral health, the platform includes a wide array of mental and behavioral health conditions through which users can connect with others. [https://www.patientslikeme.com]

The second part of this article, which will appear in our next issue, will explore the population- and industry-level benefits of social networking in behavioral health

CALL FOR PROPOSALS: NARMH 2016 ANNUAL CONFERENCE

NARMH invites proposals for contributed papers, workshops, panels, roundtable discussions, or posters at its 2016 annual conference, *Rural Mental Health: What's around the Corner,* slated for June 15-18 in Portland, ME. S

Get more information and submit your proposal online on the conference website at www.narmh.org. *The deadline is December 1, 2015, or until the agenda is filled*.

NETSMART'S TECH-ENABLED, HOLISTIC CARE INITIATIVE LAUNCHED IN LA COUNTY

As many as 70% of patients with severe mental illnesses served by the public mental system have co-morbid medical conditions such as heart disease, diabetes, asthma and COPD. Behavioral health clinicians are an integral part of "whole person" care, and need access to complete information to make informed treatment decisions. That is

why the Los Angeles County Department of Mental Health (LACDMH) and Tarzana Treatment Centers, Inc. (TTC) have launched an initiative enabling behavioral health clinicians and primary care physicians to securely share vital, authorized client and patient data in real time—often at co-located facilities—to treat both mind and body.

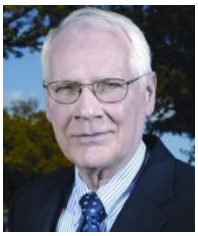
In this integrated care initiative, behavioral health clinicians at LACDMH's San Fernando Mental Health Center will have access to electronic health records (EHR) of TTC's clients' co-occurring physical health conditions and medications. Likewise, TTC will receive EHR data from San Fernando. In addition, primary care clinicians will have access to authorized EHR-based behavioral health and addiction treatment information, providing a more complete view of the person's overall health status.

The data exchange and integration is facilitated by the Netsmart CareConnect™ care coordination solution, and includes the ability for the providers to do in-depth referrals for improved continuity of care, conduct ongoing treatment monitoring, and receive emergency alerts for situations such as a failure to take prescribed medications.

CONGRESSIONAL BRIEFING: BEHAVIORAL HEALTH MATTERS TO COUNTIES

RONALD MANDERSCHEID, PHD.

[Reprinted, with permission, from Behavioral Healthcare at: http://www.behavioral.net/blogs/ron-manderscheid/congressional-briefing-behavioral-health-matters-counties?page=]



Where do you turn for behavioral healthcare if you lack necessary health insurance coverage or you can't access a provider, or you are homeless? Clearly, you turn to your local county, the safety net of last resort when all other systems fail you.

America's 3,069 counties invest more than $70 billion per year in healthcare, including county behavioral health services. These counties operate more than 750 behavioral health authorities. Such authorities exist in 23 states and cover more than 75% of the US population. Many counties help finance Medicaid, a principal source of funding for county behavioral health services.

County behavioral health authorities confront a very large and continuing problem: about 1 in 5 adults experience a mental disorder each year, and 1 in 25 have a serious mental illness; about 1 in 10 adults experience a substance use disorder each year; co-occurring illnesses are very common in these populations. Yet, more than half of those with a mental illness did not receive any care, and, astonishingly, almost 90% of those with substance use disorders did not receive any needed care last year.

All of these facts were presented in a very important Congressional Briefing held today, October 28, and sponsored jointly by the National Association of Counties (NACo) and the National Association of County Behavioral Health and Developmental Disability Directors (NACBHDD).

Three members of the House joined the briefing and offered remarks. They included Rep. Paul Tonko of New York, Rep. Doris Matsui from California, and Rep. Tim Murphy from Pennsylvania.

County is the safety net. Sallie Clark, the new NACo president, led a panel of presenters. After documenting the very important role that counties have in delivering health and behavioral health services, she noted that counties are the primary health safety net in the United States and that counties also administer wrap around human services, such as housing, food assistance, and transportation supports.

Cherryl Ramirez, NACBHDD Board President and the Executive Director, Association of Oregon Community Mental Health Programs, eloquently described how county behavioral healthcare programs serve those most in need, and provide not just treatment services, but also prevention and rehabilitation. A major challenge confronted by every county, in her view, is lack of adequate service funding—from the SAMHSA block grants to Medicaid. Clearly, counties could do a much better job if the SAMHSA block grants were funded fully, the Institution for Mental Disease (IMD) restrictions on Medicaid funding were modernized, and Medicaid payments were extended to pre-adjudicated detainees in county and city jails.

Robert Sheehan, the new executive director of the Michigan Association of Community Mental Health Boards and recent Executive Director of the Community Mental Health Authority of Clinton, Eaton, and Ingham Counties in Michigan, recounted the dramatic progress being made in Michigan under the Affordable Care Act, especially the new Medicaid expansion. From his perspective, local authorities are responding to the needs of the newly-insured populations, while, at the same time, seeking to increase their emergency response capacity to mitigate the need for long-term intensive care and to reduce the incarceration of persons with mental health and substance use conditions in county and city jails. As a result, counties have a major need for resources and technical assistance to build their emergency response capacity.

Harvey Rosenthal, the executive director of the New

York Association of Psychiatric Rehabilitation Services, is a nationally-recognized mental health advocate. In his comments, he emphasized the essential role of SAMHSA in fostering trauma-informed care and the fundamental goal of recovery. He also noted a growing disparity between the increasing number of persons seeking care and the static number of providers available to serve them. In his view, peer support is a major and fundamental tool for addressing this disparity. If we are to access this tool effectively, resources will be required for short-term training.

A large number of congressional staff and community representatives attended this briefing in person, and a large number also linked in to the simulcast. NACo Executive Director Matthew Chase concluded, "As Congress considers legislation to address challenges in behavioral health systems, counties can play a critical role in shaping effective policy solutions. We look forward to continuing to work with Congress to improve responses to behavioral health needs in communities across the country."

You can access an infographic from the briefing here. This infographic also contains a succinct list of some major actions NACo and NACBHDD would like the Congress to address in the short term.

ACA Could OPEN BEHAVIORAL Care to Millions

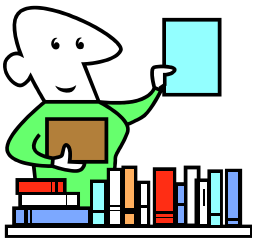
The ACA potentially could provide expanded access to behavioral healthcare for 5.3 million low-income, uninsured people in need of substance use or mental health treatment. The only caveat is that the individuals must live in states with expanded Medicaid coverage, now roughly 50% (2.7 million) of those 5.3 million individuals, according to a new SAMHSA report. Read or download the report, *State Participation in the Medicaid Expansion Provision of the Affordable Care Act: Implications for the Uninsured Individuals with a Behavioral Health Condition*, at http://www.samhsa.gov/data/sites/default/files/report2073/ShortReport-2073.pdf

Around the States: An Update

- **Florida.** Governor Rick Scott (R) has extended a behavioral health integration pilot program in Broward County to include Pinellas and Alachua Counties. As part of the expansion, the Florida Department of Children and Families (FDCF) is now required to broaden data tracking of all local, state and federally funded behavioral health services to include both the Florida Department of Health and the Florida Agency for Health Care Administration. The FDCF also will analyze their level of integration and develop an integration improvement model that can be implemented across the State.
- **Illinois.** The Illinois legislature has overridden a veto by Governor Bruce Rauner (R) and enacted a law to address the growing problem of opiate abuse and to expand the State's drug court system. Under the measure, Medicaid and most private health insurance plans that cover prescription medications now must cover at least one medication that reverses opioid overdose. It requires police and fire departments to stock opioid overdose reversal medications and authorizes school nurses to do the same.
- **Indiana.** The State's new initiative, Recovery Works, pays for behavioral health care for convicted felons who are sent to community treatment centers instead of to jail or prison. Offenders will receive vouchers worth up to $2,500 for behavioral health assessment, screenings, and treatment, or to pay transit to and from treatment centers. Referrals to the program—which will serve adults with incomes under 200% of the federal poverty level—can be made by courts, probation and parole officers and community correction managers.
- **Kansas.** The Kansas Department of Health and Environment and the State Department for Aging and Disability Services (KDADS) have postponed a plan to merge 7 Medicaid disability support service waivers, each covering a specific type of disability (including serious emotional disturbances) into a single waiver for child disability support services and another waiver for adult disability support services. Originally planned for implementation on July 1, 2016, the new waivers will be delayed until January 1, 2017. Part of the delay, apparently, is to incorporate stakeholder feedback; part is the requirement that CMS approve the waiver restructuring.
- **Louisiana.** With the election of John Bel Edwards (D) as Governor, the prospects for Medicaid expansion have increased markedly. While his predecessor Bobby Jindal was vehemently opposed to ACA's Medicaid expansion in any form, the new Governor already has signaled his intent to move expansion forward in the State.

- **MONTANA.** Montana is the 30th state to have expanded Medicaid under the ACA. As in other Republican-controlled states, the now-HHS approved plan is "Medicaid expansion with a twist." Beneficiaries of the expansion are required to pay premiums of up to 2% of their income. HHS has cleared this alternative expansion proposal, enabling thousands of low-income people, including many with behavioral disorders, to seek and get health insurance coverage.
- **NEW JERSEY.** Governor Chris Christie (R) has signed into law a measure that bans the sale of powdered alcohol products—sold under the name brand, Palcohol©—in the State. The bill had broad bipartisan support due to its likelihood for abuse, particularly by underage drinkers.
- **NEW YORK.** New York taxpayers can now make tax-free donations to a fund designed to help reduce and, ultimately, end the stigma associated with mental illnesses by marking a check-off box on their State tax form. The check-off box will make its first appearance in the 2015 income tax forms.
- **NORTH CAROLINA**. The State's Medicaid program is changing from an emphasis on fee-for-service to one based on managed care. Under a new law, the State DHHS must develop a 2-part managed care system. The first tier will create a system of provider-led entities to oversee capitated Medicaid funding and develop provider networks in 1 of the State's 6 Medicaid regions. The second part will generate 3 managed care contracts to oversee capitated funding and services statewide. However, the State needs to develop and get CMS approval of a waiver before the transition can take effect. Full implementation is not likely before FY2020. Critically, *behavioral health, which has operated under its own managed care system since 2011, will remain carved out from the new system for 4 years following initial transition*
- **OREGON.** The Oregon Department of Human Services (DHS) has settled a 2012 class action suit that charged the State with ADA violations by relying on sheltered workshops as key employers for individuals with ID/DDs. The settlement, affecting around 7,000 individuals in all, requires the State to expand its Employment First program over the 7 years, moving over 1,100 working-age adults with ID/DDs from sheltered workshops to competitive jobs and supportive services. Further, no fewer than 4,900 youth will receive supported employment services to help them get and and keep jobs in the community.
- **TEXAS**. The State legislature has created a 13-member House Select Committee on Mental Health, to be led by Representative Four Price. Established following the death of Sandra Bland while in custody following a traffic stop, the committee will review the behavioral health system, including substance abuse treatment, and recommend ways to improve early identification of mental illness and increase collaboration among entities that deliver care, including the criminal justice committee. Working between now and the start of the 2017 term, the committee also will also look at how to measure and improve outcomes; examine challenges of providing care in underserved and rural areas of the state; and identify the challenges of providing care to veterans and homeless Texans.
- **WEST VIRGINIA.** The State has launched its first 24-hour behavioral health hotline (844-HELP4WVA). A collaboration between the West Virginia Department of Health and Human Services and First Choice Health Systems, the hotline was designed to assist individuals in need of services, including those for substance use disorders. The hotline provides callers with information about treatment options and immediately connects them with treatment staff. The line also provides appointment reminders and arranges transportation assistance.

ON THE BOOKSHELF: RECENT PUBLICATIONS OF NOTE



- **ROBERT WOOD JOHNSON FOUNDATION.** The County Rankings and Health Roadmaps Project's latest report, *State Health Gaps: What's Driving the Health Differences Across the State and How Can These Health Gaps Be Closed*, describes health differences on a state-by-state basis. It can help states better understand the size and nature of health gaps across their counties; the factors influencing resident health; and the ways gaps can be addressed by states and counties. To review this report, go to: http://www.countyhealthrankings.org/health-gaps and select your home State.
- (A Video) **ALLIANCE FOR HEALTH CARE REFORM**. A briefing, *High-Need, High-Cost Patients: The Role of Behavioral Health,* discusses current initiatives to integrate behavioral and physical health care services in order to improve quality of care and reduce overall health care costs. Check out the video on YouTube at: https://www.youtube.com/watch?v=AKWqpx8G1eg
- **OFFICE OF THE MAYOR, NEW YORK CITY.** A white paper, *Understanding New York City's Mental Health Challenge* was issued just before the launch of NYC Thrive, an initiative d to help prevent and treat behavioral disorders among residents of the Nation's largest city. Read the report that explains the rationale for NYC Thrive at: NYC Thrive Report

- **ROBERT WOOD JOHNSON FOUNDATION/HEALTH AFFAIRS.** *Enforcing Mental Health Parity* explores how mental health parity has been implemented and enforced 5 years after enactment of the Mental Health Parity and Addiction Equality Act. Read the document: http://healthaffairs.org/blog/2015/11/13/health-policy-brief-enforcing-mental-health-parity/
- **MILBANK MEMORIAL FUND.** *State Actions to Promote and Restrain Commercial Accountable Care Organizations (ACOs)* draws on evidence from the literature and 4 case studies to identify tools that state governments can use to promote the benefits of ACOs while mitigating their potential risks. It explores how state policymakers can respond to ACO development; what is in the best public interest; and what lessons can be gleaned from commercial health insurance and managed care regulatory frameworks? Read the full report at: States and ACOs
- **NATIONAL TECHNICAL ASSISTANCE CENTER FOR CHILDREN'S MENTAL HEALTH.** *Learning Community Supports Interagency Planning for Youth with Co-occurring Intellectual/Developmental Disabilities and Mental Health Disorders,* describes lessons from a learning community developed by Georgetown University's National Technical Assistance for Children's Mental Health to assist cross-agency teams and families in 3 states to improve care for children with intellectual/developmental disabilities (IDD) and behavioral disorders. Read the full report at: http://gucchdtacenter.georgetown.edu/publications/MHDDReport.pdf

MARK YOUR CALENDAR

- **CALIFORNIA DEPARTMENT OF HEALTHCARE SERVICES MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES.** *Behavioral Health Forum*, December 14, 2015, 9:00am -2:30 pm (PST), DHCS Headquarters Auditorium, 1500 Capitol Avenue, Sacramento, CA. Also available as a webinar. To register to participate in the webinar, go to: https://attendee.gotowebinar.com/register/3376310308045184257
- **COLLEGE FOR BEHAVIORAL HEALTH LEADERSHIP/APHA BEHAVIORAL HEALTH SECTIONS.** The organizations are convening a *1-day seminar on population health*, January 20, 2016, Washington, DC. The seminar will explore elements of population health and how behavioral health and primary care can work to affect the triple aim of improving care for individuals, reducing costs, and improving health. NACBHDD Executive Director Ron Manderscheid is co-instructor. $175/person; lunch included. Register at www.acmha.org.
- **CALIFORNIA INSTITUTE FOR BEHAVIORAL HEALTH SOLUTIONS.** The 15th annual leadership institute, *Developing Leaders for a Changing Behavioral Health Ecosystem*, will convene February 2-4, 2016, at the Kellogg West Conference Center & Hotel, Pomona, CA. Two follow-up sessions will take place in March, and another in May. For more information, go to: http://www.cibhs.org/event/spring-2016-cibhs-leadership-institute
- **SAMHSA**. *Electronic Health Record Boot Camp—An Online Training Program* is a SAMHSA-sponsored, 6-week, one-hour-a-week live, interactive training session, led by experts in the field to help behavioral health providers and organizations beef up their capacity in the growing digital health care environment. Sessions will be 3:00 pm – 4:00 pm (ET), Wednesdays, February 10 through March 16, 2016. Stay tuned for updates about how to register.
- **NACBHDD**. *Spring Board meeting*, Sunday, February 21, 2016, 1:30 pm - 4:30 PM, ET, Cosmos Club, Washington DC. Stay tuned for more information.
- **NACBHDD**. *2016 Legislative and Policy Conference*, Monday, February 22, 2016, (8:00 am ET), to Wednesday, February 24, 2016 (1:00 pm, ET), Cosmos Club, Washington, DC. More information to come.
- **NARMH**. *Board Meeting*, Wednesday, February 24, 2016, (8:00 am to 4:00 pm ET), Cosmos Club, Washington, DC. More information to follow.
- **NJAMHAA**. The New Jersey Association of Mental Health and Addiction Agencies will convene its 2016 conference, *Innovating for Progress, Partnering for Solutions*, on April 13-14, 2016, Renaissance Woodbridge Hotel, Iselin, NJ.
- **NATIONAL ASSOCIATION FOR RURAL MENTAL HEALTH**. NARMH's 2016 Annual Conference is slated for June 15-18, 2016, in Portland, Maine. Titled, *Rural Mental Health: What's Around the Corner?,* the conference will explore the opportunities and challenges as our health, behavioral health, and social service systems respond to healthcare reform initiatives and the evolving healthcare market. For more details and to register online, visit the conference website at www.narmh.org.
- **AMERICAN ASSOCIATION FOR THE TREATMENT OF OPIOID DEPENDENCE**. The 2016 annual AATOD conference will convene October 29-November 2, 2016, Baltimore, MD. For more information or to respond to a call for presentations, go to: http://www.aatod.org/2016-aatod-conference-baltimore/

###